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Independent Study Projects

Title

UCSD SOM 3rd Year Survival Guide

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UCSD School of Medicine 3rd Year Survival Guide

Rationale

The transition from the pre-clinical curriculum to the hospital wards is arguably the most exciting, yet anxiety-provoking time in a medical student's career. In spite of a vigorous and informative *Clinical Transitions Week* orientation, students often feel ill-prepared and uninformed for the pending transition. Students are often left to discover proper ward etiquette, specific clerkship cultures and personalities, and Electronic Medical Records in a trial-by-fire manner that can often leave a highly capable student discouraged if they are not able to understand and adapt to their role appropriately. The psyche and confidence of a budding student doctor is fragile and vulnerable and these pressures can hinder a student's desire to learn and engage on a clerkship.

Prior to this project, there was no single document or reference available to medical students to describe the various aspects of the third year of medical school at UCSD School of Medicine. Various resources were scattered, difficult to access, and did not incorporate the input of all levels of medical education (i.e. students, residents, attendings, administration etc.). The UCSD School of Medicine 3rd Year Survival Guide was designed to be used in conjunction with Clinical Transitions Week to increase student preparedness and smoothen the transition to the clinical wards.

Objectives

The primary goal of the project was to create a complete and comprehensive guide for third year medical students at UCSD School of Medicine. Specific goals are as follows:

1. Provide students with easy access to information regarding role and responsibilities, specific clerkship rotations, grading policies, etc.
2. Consolidate existing clerkship-transition informational resources
3. Compile a representative sample of peer-based answers to provide valuable insider information
4. Increase third year student preparedness
5. Navigate the issues of adapting to the various cultures and personalities housed within a new clerkship
6. Develop a guide that will be useful and reusable for an unforeseeable number of cohorts of medical students

Methods

1. **Survey Group:** A group of 14 medical students were selected to represent the breadth of diversity at our institution with respect to age, gender, marital status, education level, and perceived personality type. Seven students were chosen from the Class of 2016 and 2017. Students from the Class of 2016 completed surveys for their final two blocks and students from the Class of 2017 did the same for their first two blocks of their third year. Students were selected contingent on a commitment to fully complete the surveys throughout the academic year in a timely fashion.
2. **Creating the Survey:** The survey consisted of quantifiable data using questions with answers rated on a Lichert-like scale at the end of each clerkship. There were also free response answers to allow for comprehensive input. A comprehensive survey was additionally administered at the end of the year to gain insight into general student perspectives on third year.

3. Analysis and Writing of the Report: Participants' answers were recorded, analyzed and compiled into a finalized guide. This report will be available to all UCSD School of Medicine students.

Achievements

At the completion of this project, a complete and comprehensive 3rd year survival guide was created. Given the information was obtained from a diverse survey group, this information should be representative of most third year medical students. The content of this guide includes general third year information (ie. shelf exams, EMR, food, etc.), clerkship-specific information, and advice in regards to common Do's and Dont's. In conjunction with the Clinical Transitions Week, this survival guide will serve as a valuable resource to UCSD School of Medicine students for the transition process and throughout their third year.

UCSD School of Medicine 3rd Year Survival Guide

A Student Perspective

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Introduction

Welcome to the start of your 3rd year of medical school! You are finally done with the classroom setting and ready to do what you came to medical school for, take care of patients in the hospital! The transition to starting clinical clerkships is very abrupt and can be quite overwhelming for students. The purpose of this guide is to not provide you with all the answers, but help ease the transition. The information provided in this guide is a summary of student responses and will hopefully not only allow you to pick your clinical rotations, but also succeed in them!

Inside you will find some general 3rd year information, specific information on the various clinical clerkships and specific rotation sites, as well as advice from those you have been there before. We hope this helps. Enjoy!

Much love,

Soroosh Amanat
UCSD School of Medicine, Class of 2016

Section 1: General Information

A. Clinical Clerkships

The 3rd year of medical school consists of 7 clinical clerkships listed below.

Rotation	Length
Surgery	8 weeks
Medicine	12 weeks
Pediatrics	8 weeks
Neurology	4 weeks
Psychiatry	6 weeks
ObGyn	6 weeks
Primary Care	Year-Long

The rotations are further broken down based on various specific sites.

Rotation	Specific breakdown
Surgery	4 weeks general surgery 4 weeks specialty surgery Two 2 week selective blocks
Medicine	4 weeks inpatient #1 4 weeks inpatient #2 4 weeks outpatient
Pediatrics	4 weeks inpatient 4 weeks outpatient
Neurology	2 weeks inpatient 2 weeks outpatient
Psychiatry	6 weeks inpatient
ObGyn	2 weeks labor and delivery 2 weeks gynecology 2 weeks outpatient
Primary Care	Attend clinic with preceptor once per week (either Tuesday or Friday) for the entire year. Of note, you do not attend primary care clinic during your surgery rotation.

B. Grading

The grading system in the 3rd year consists of Honors, Near Honors, Pass or Fail. Selectives are only graded on a pass or fail basis.

For most clerkships, your grade is based on clinical evaluations and shelf exam. In general, evaluations count for 75% of your grade, while shelf exam accounts for 25%. However, **in order to qualify for Honors, your shelf exam score must be**

higher than the mean score during that block. While the shelf exam is important, it is difficult to get honors if you do not have great clinical evaluation scores.

Grades are typically announced 6 weeks after the completion of the block.

C. Shelf Exams

Shelf exams are standardized national exams administered to medical students in the country at the end of a particular clerkship. Exams consist of **100 multiple-choice questions** with an allotted time of **2 hours** to complete the test. Your score is calculated based on performance of all U.S. medical students. All questions are clinical vignettes with long question stems with a similar style to USMLE Step 1. Questions are primarily focused on diagnosis and treatment. **A passing score on the shelf exam is 60.**

Shelf exam scores are typically announced 1-2 weeks after the exam.

D. Daily Expectations

Expectations vary by rotation and individual residents, attending physicians and teams. If medical student expectations are not offered, we recommend asking early in the rotation what the team expectations are for medical students. In general, students are expected to pre-round on their patients, present their patients during rounds with a well-formalized assessment and plan (even though it may be wrong), and help out the team as needed throughout the day. You are not expected to know the answer to every question. **People just expect you to show up on time, be respectful of others and be excited to learn!**

E. Requesting Time Off

Requesting time off during your clinical rotations is surprisingly not too difficult. However, any given rotation can deny your request for time off. Traditionally, the rotations most amenable to allowing students to request days off for important events are Psychiatry and outpatient months (particularly outpatient medicine). Also, remember that during selectives and outpatient months, you have weekends off. **If you know there is a particular event that you would like to attend, plan your schedule accordingly to try to line up psychiatry or an outpatient month at that time.** Finally, if you need to request time off, request specific dates **at least 4-6 weeks in advance, if not more.**

F. Definitions

Similar to most medical information, as you enter third year you will encounter medical jargon that you cannot comprehend. This section will hopefully help familiarize you with some of these terms.

Pre-rounding: This means checking on your patient in the morning before rounds. This includes gathering all the information since you last saw them to update the rest of the team on rounds. Some services expect you to finish your progress notes during this time as well (ie. surgery), but most give you time after rounds. General routine:

- A) See the patient and ask how they feel, any new complaints, etc.
- B) Perform a physical exam everyday
- C) Record vital signs.
- D) Track down results of labs or radiographic studies done since yesterday
- E) Read any consult or nursing notes

Rounding: This is the time the team discusses the assessment and plan for all the patients with the attending physician. These can either be table or bedside rounds. Bedside means the patient presentation is done outside the patient room or at bedside and attending will exam the patient at that time. Table rounds include only patient presentations and attendings will exam patients later. Rounds are very educational and your opportunity to shine. You will have an opportunity to provide full patient presentations with your own assessment and plan.

New admit: This means a patient from the emergency department is being admitted to the hospital for an overnight stay. This involves seeing the patient in the ED, evaluating the patient and writing an H&P.

H&P: History and physical. This is the type of note written for new patients. This will include information such as PMH, PSH, medications, allergies, family history and social history that is often excluded from progress notes and daily presentations.

Progress Note: This is a day-to-day note written to communicate important new information in regards to patient's condition or assessment and plan.

Pimping: This is when an attending physician or resident asks you a question and waits for your response. While it can be quite intimidating, the purpose of pimping questions is to assess your knowledge and provide important teaching points.

Bird-dogging: Surgery term where you sit in the pre-op area waiting for the patient to be rolled back to the operating room. Once the patient is being rolled back, you will let the residents know, so they can come down for the surgery.

PACU: Post-anesthesia care unit. Area where patients are taken to after surgery.

G. Members of a Team

Attending Physician: Physician that is responsible for the care of all patients on your team.

Senior Resident: Generally a 2nd or 3rd year resident

Intern: 1st year resident. These residents may have a future in that specialty or may just be going through a preliminary year before going into another specialty.

In general, medicine has a hierarchical system. This system is emphasized in some specialties more than others. Your most open line of communication will be with your interns. They are there to help you! You can feel free to ask attendings and senior residents questions, but as a rule of thumb, ask interns first.

H. Hospital Affiliations

The UCSD SOM is affiliated with many hospitals in the San Diego area that provides a diverse clinical experience for medical students. Below are a list of the various hospital affiliations and what rotations are offered at each.

UCSD Hillcrest (main hospital): Inpatient and Outpatient Medicine, Surgery, Psychiatry, ObGyn, Neurology

UCSD Thornton (La Jolla): Surgery, Neurology

Rady Children's Hospital: Inpatient and Outpatient Pediatrics

VA (La Jolla): Inpatient and Outpatient Medicine, Surgery, Psychiatry, Neurology

Navy (Balboa Park): Surgery, Inpatient and Outpatient Pediatrics

Scripps Mercy (Hillcrest): Inpatient Medicine, ObGyn, Trauma Surgery

Scripps Green (La Jolla): Inpatient Medicine

I. Living Situation/Traffic

One thing to consider with third year is your living situation. Third year is particularly busy and while you may not spend much time at home, it is important to come home to a group of friends or loved ones who can support you. During third year, students often move to Hillcrest to be closer to the main hospital. Hillcrest is a very fun area that is walking distance to not only the hospital, but also many restaurants and bars.

However, please consider that all rotations are based off a lottery system and thus, there is a good chance you will be rotating at various different sites. With that said, please be aware that the traffic in San Diego can be bad between the hours of 7-9 am and 4-6:30 pm. Traffic traditionally is as follows:

- Morning commute: Traffic is in the South to North direction
- Afternoon commute: Traffic is in the North to South direction

Thus, if you do choose to live in Hillcrest, be aware that there will be certain rotations that you will likely be sitting in traffic during your commute.

J. Taking "Call"

Please refer to individual clerkships for taking call and medical student expectations. Call rooms are available at Hillcrest (West Wing), Scripps Mercy and Rady Children's Hospitals.

K. EPIC Templates (Hillcrest and Thornton)

Templates are an easier way to write notes in EPIC. When creating a new note, you can use dot phrases to pull up your templates. For example, if you have an H&P template named SAHP, you use the dot phrase: .SAHP and it will put up the template with pre-populated information. Templates make life easier, but one also must be careful to avoid mistakes and make edits as necessary.

Also, you can use other people's templates. Directions:

1. Click EPIC icon on top left
2. Smart Phrase Manager
3. Enter name of user (ie. Smith, John), then click Go
4. Double Click on template you want to use
5. Click "Owners and Users" tab near top of window
6. Click "Add Myself" on bottom right
7. Click "Accept"

The template will now be available for you to use when you use the smart phrase.

L. Pager System

Every healthcare worker in the hospital will have a pager. The paging system is HIPAA-compliant and the most commonly used method to communicate information amongst various providers. The paging system is only available if you are connected through the UCSD Internet server. The paging system can be accessed at webpaging.ucsd.edu.

Typical page outline:

Re: Patient John Smith, MRN 123456789. Can you please call to discuss antibiotic regimen? Thanks!

Sally, p1234, ext. 6340

M. Parking

Free parking is available for rotations at the Navy, Rady Children's and Scripps hospital locations. A UCSD parking pass must be purchased for rotations located at Hillcrest, Thornton or the VA through UCSD Parking Services. Various parking pass options are available including: 10-day pass, 1-month pass and Annual pass.

N. Food

Food becomes an essential part of third year. Here is a little breakdown of the various food options available at different locations:

Naval Hospital: Very cheap food in the cafeteria!

Rady's Childrens: Food is provided at daily lunch conferences

Scripps locations: Food is provided at daily lunch conferences

VA: Cafeteria provides salads, sandwiches, pizza, grill and entrees at decent prices.

Hillcrest: Cafeteria provides salads, sandwiches, pizza, grill and entrees. Prices are relatively expensive. Very poor food options available on weekends. Highly recommend the breakfast omelettes and waffles!

Thornton: Great selection and delicious, but relatively expensive.

During inpatient medicine rotations at VA and Hillcrest, lunch is provided twice per week

Section 2: Clerkship Information

Neurology Clinical Site Comparison			
Location	VA/Thornton	Hillcrest	Navy
Average Hours	7 am – 5 pm	6:30 am – 6 pm	8 am – 5 pm
Daily Schedule	7-8 am: Preround 8-11 am: Round 11-6 pm: ED Consults		Rounds Clinic Inpatient admissions
Overnight call	Home call		
Pro	More downtime for studying	More practical learning Great clinical exposure	Interesting cases
Con	Slow service Less practical learning	Very busy service	Slow service
Dress	Professional		

Advice before starting Neurology rotation:

- Briefly review neuroanatomy and different pathways
- Be prepared to localize the lesion
- Information to be familiar: stroke code protocol, antiplatelet criteria and options, imaging modalities, neurocognitive dementias
- ***A lot of students are confused about their roles on the neurology service. Best thing is to ask the resident for their medical student expectations and be proactive. Recommend seeing as many consults and writing as many notes as possible.***

What items should you carry in your white coat?

- Reflex hammer
- Penlight
- Safety pin
- Tuning fork
- Vibration fork
- Stethoscope

What resources should I use for the shelf exam?

- Dr. K notes
- Blueprints
- Pre Test

Inpatient Pediatrics Clinical Site Comparison

Location	Rady's	Navy
Average Hours	6 am – 6 pm	5:30 am – 5:30 pm
Daily Schedule	6-7:30 am: Preround 7:30-8 am: Morning Report 8-12 pm: Family-centered rounds (Specialty and General) 12-1 pm: Lunch conference 1-6 pm: Teaching, new admits, update notes	5:30 – 6 am: Sign-out 6-8 am: Preround 8-9 am: Morning Report 9-11 am: Rounds 11-5:30 pm: New admits, finish notes, teaching
Overnight call	4 nights of call during month; must admit 2 new patients per call	None
Pro	Dedicated teaching sessions Free Parking Free lunch Wide variety of exposures including specialty and general pediatrics	Good diversity Free parking
Con	Exposure slightly limited based on team assignment Notes do not count, so feel less useful	Less complex pathology Slower service EMR is difficult to use
Dress	Professional	Scrubs

Advice before starting inpatient Pediatric rotation:

- Some people go into this rotation never having handled or interacted with an infant or toddler before. Use this opportunity to get comfortable handling infants!
- Children are completely different than adults
- Review the pediatric exam before starting your inpatient rotation
- Be prepared to make long differential diagnoses
- Pediatric history places focus on birth, development and vaccine history, so make sure you obtain this information during interviews
- Seize the opportunity when you have a chance to present a patient or teach a topic. This is where you have a chance to stand out.
- Ask for updates from interns before presenting your patient
- Enjoy learning from excellent doctors and take advantage of all the teaching
- ***Specific to Rady's: Keep in mind that everyone has input on your final grade including your residents, chief residents, etc.***

Outpatient Pediatrics Clinical Site Comparison

Location	Rady's	Navy	Mid-City
Daily Schedule	8 am - 12 pm: Clinic 12:30- 1:30 pm: Noon Conference 1:30 – 5:30 pm: Clinic	7:30 – 9 am: Morning Report 9 am - 12 pm: Clinic 12- 1 pm: Lunch 1 - 4 pm: Clinic	8 am - 12 pm: Clinic 12 - 1 pm: Lunch 1 – 4 pm: Clinic **Only spend 1 day/week at Mid-City; Rady's outpatient for rest **
Experience Breakdown	General Peds – 6 days Newborn – 2 days Specialty – 12 days	General Peds – 10 days Newborn – 5 days Specialty – 5 days	General Peds – 10 days Newborn – 2 days Specialty – 8 days
Weekends?	Off	Off	Off
Pro	More full-spectrum pediatrics More exposure to specialties	More exposure to general pediatrics Increased responsibility and autonomy	Very diverse Underserved population Both Mid-City and Rady's
Con	Less general pediatrics and nursery Less autonomy	Less exposure to specialties Complicated EMR system Increased responsibility Less complex pathology	Street parking difficult
Dress	Professional		

Advice before starting inpatient Pediatric rotation:

- Review developmental milestones
- Review anticipatory guidance
- Do Rady's outpatient modules
- Children are completely different than adults
- Smile! Kids do not like unhappy medical students!

What items should you carry in your white coat?

- Stethoscope
- Penlight
- Stickers!

What resources should I use for the shelf exam?

- Blueprints
- Case Files

L&D Clinical Site Comparison		
Location	Hillcrest	Scripps Mercy
Average Hours	5 am – 6 pm	5 am – 5 pm
Daily Schedule	5-6:30 am: Preround 6:30-7:30 am: Post-partum Rounds 7:30-8:30 pm: Board Rounds 8:30-6 pm: Triage patients, C-sections, deliveries	5-7 am: Preround 7-9 am: Rounds 9-5 pm: Wait to deliver babies
Overnight call	In-House	
Pro	Wide variety of clinical problems Great teaching with residents and attendings	More autonomy 1:1 attending time Free food and snacks
Con	High-risk OB center, so may be more C-sections than vaginal deliveries	Less mentorship Must be self-motivated Often forgotten about
Dress	Scrubs	

How does call work?

- 24-hour overnight call
- You have essentially the same responsibilities as regular day on service. However, since you are the only medical student, you receive greater exposure and hands-on experience. Your call is finished at 5 am (Hillcrest) or 7 am (Scripps Mercy).

Advice before starting L&D rotation:

- Do not expect to deliver a baby. If it happens, fantastic, but not everyone gets the opportunity, particularly if the interns are just starting their year. Setting proper expectations is very important and will allow you to have a better experience.
- If interested in ObGyn, recommend Hillcrest rotation.

Gynecologic Rotation Comparison		
Rotation	Benign Gyn	Gyn Onc
Average Hours	6 am – 4 pm	5 am – 6 pm
Daily Schedule	Highly variable	5 am – 7: Pre-rounds 7 am: Rounds or surgery 8 – 5 pm: Clinic 5- 6 pm: PM rounds
Overnight call	Home/Pager Call	
Pro	Bread and butter Gyn surgeries Lighter hours than Gyn Onc	Similar to surgery rotation More hands-on surgical opportunities
Con	Wide variability in hours No intense oncologic surgeries	Long hours

How does call work?

- Both rotations have a pager call system. You will have your pager on or near you when you go to sleep at home. If a patient is admitted overnight, you will be paged and have to go in earlier in the morning to round on that patient and write a progress note (not an H&P). For example, if you receive a page with a new admit, instead of getting to the hospital at 5 am to round on your 1 patient, you will get there at 4:30 am. Your resident will inform you the updated order of pager call via email every night.

Advice before starting gynecology?

- Schedule is highly variable, so flexibility is key!
- Read the Pink ObGyn orientation booklet!

What items should you carry in your white coat?

- Stethoscope
- Pink ObGyn orientation booklet

What resources should I use for the shelf exam?

- APGO questions
- Blueprints
- Case Files
- Pink booklet

General Surgery Rotation Comparison

Team	Trauma/White	Burn	Navy	Surg/Onc	Halasz	Blue	Peds
Average Hours	5:30 - 6	6 am-6 pm	5 am-6:30 pm	5 am-6 pm	5 am-6 pm	5 am - 7 pm (Variable)	4 - 5:30 pm
Daily Schedule	See below						
Overnight call	Trauma call	Trauma call	No	No	One overnight call	No	No
Pro	Predictable hours ICU management Variety of cases Good for shelf exam	Dr. Potenza is amazing! ICU management Hands-on OR experience	Lots of surgical exposure and independence Great teaching	Amazing variety of surgeries Great teaching on management of surgical patients	Lots of OR time Bread and butter general surgery Practice suturing Good teaching	Very nice surgeons Lots of GI on shelf	Exposure to all sorts of general surgery High volume Cool surgeries
Con	Limited OR time Short time on each service	Surgeries are repetitive and can get boring	EHR is difficult to use	Lack of consistent attending attention	Long hours	Long hours	Long hours Limited hands-on Navy residents can't evaluate you

OR ETIQUETTE

- Prior to the start of the first surgery, enter the OR and introduce yourself to the scrub tech and circulator.
- Write your name and year on the white board under medical student (ie. John Smith, MS3).
- Ask the scrub tech/circulator if you they would prefer you to grab your own gown and gloves
- Help bring patient into room, move patient over to bed, move patient bed out of room, then go scrub when everyone is ready
- Put on gown and gloves (only after attending and residents have done so)

Make friends with the scrub tech and circulator. They can be your best friend or worst enemy in the OR.

More specific rotation schedules based on clinical site are below. However, please remember these schedules are just examples and actual schedules are highly team dependent.

<p><i>White Surgery (Hillcrest)</i></p> <ul style="list-style-type: none"> • 5:30 – 6:45: Update the list (HPI, current meds, overnight events, vitals, I/Os, micro) • 6:45 – 8: Rounds with residents and attending <p style="text-align: center;">M-W-F: Surgeries all day T-Th: Wait for Consults Wednesday afternoons: Clinic</p>
<p><i>Trauma Surgery (Hillcrest)</i></p> <ul style="list-style-type: none"> • 5:30 – 7: Preround • 7 – 9: Round • 9 – 6: Wait for traumas • During the day: Help write discharge summaries, paging/responding to pages for the residents, and f/u on imaging results from patients in the trauma bay.
<p><i>Surgical Oncology (Thornton)</i></p> <ul style="list-style-type: none"> • 5 – 6 am: Occasional pre-rounding (not always required) • 6 – 7:30 am: Rounds • 7:30 am – 5 pm: OR • 5 – 6 pm: PM rounds <p style="text-align: center;">Monday afternoons: Teaching conference (ie. Pimping session)</p>
<p><i>Halasz (VA)</i></p> <ul style="list-style-type: none"> • 5 – 6 am - Pre round • 6 am - sign out • 6:15 - 7/7:30am - rounds with team and chief resident • 7:30 - 8 am- finish writing notes • 8 am – 5pm: OR • 5:30 pm – PM Rounds <p style="text-align: center;">Monday and Wednesday Afternoons: General surgery clinics</p>
<p><i>Burn (Hillcrest)</i></p> <ul style="list-style-type: none"> • Monday, Wednesday, Friday - Round: 7 am; OR cases after • Tuesday - Round: 8 am; help residents the rest of the day • Thursday - Round: 8 am; clinic from 1-4 pm (3rd floor)
<p><i>Blue (Thornton)</i></p> <ul style="list-style-type: none"> • Variable • 1 Clinic/week; most days spent in the OR or helping with floor duties

Peds Surgery (Rady's)

- 4/430 – 5 am: Pre-Preround
- 5 – 6 am: Preround with residents
- 6 – 7 am: Round with Fellow
- 7 – 730 am: Prep for cases, distribute cases,
- 730 am - 330/5 pm: OR
- 5 – 5:30 pm: PM Rounds

1 clinic afternoon per week, your choice who and when

Navy

- 5 - 6 am: Pre-round
- 6 – 7 am: Round
- 7 – 8 am: Morning Report
- 8 am – 3 pm: OR
- 3 – 5:30 pm: Notes, rounding, or surgery

Specialty Surgery Rotation Comparison

Team	Neurosurgery	Urology	CT	Transplant	ENT	Ortho	Plastics	Gold/Vasc
Hours	5 am-6 pm	5 am-6 pm	5 am – 6-8 pm	7 am-5 pm	7 am-5 pm	4 am – 5 pm	Variable	5 am – 5 pm
Schedule	See Below							
Call	Optional	No	No	Optional	No	Optional	No	Once
Pro	Lots of autonomy Comfortable with simple procedures	Can have lots of OR or clinic time New tools and techniques	Small team One-on-one with attendings Hands-on	Cool surgeries Multi-disciplinary approach Lots of medicine	You get to customize your rotation No rounding	Hands-on Residents are very fun	Lots of variety Lots of suturing No pre-rounding	Can use bone saws Easy to hide
Con	Super long days with long surgeries Limited opportunities with Sub-I	Change location every week so less continuity Busy service	Repetitive Long hours	Minimal OR time Less hands-on	Not part of a team	Long hours	No clear role as not member of a team Highly variable schedule	Little OR time Repetitive

More specific rotation schedules based on clinical site are below. However, please remember these schedules are just examples and actual schedules are highly team dependent.

Neurosurgery

- 4:30 – 6 am: Pre-round
- 6 – 8 am: Imaging rounds (Neuroradiology room) followed by Rounds with Chief Resident
- 8:30 – 3 pm: OR
- 3 – 6:30 pm: Notes, rounding or OR

Friday Afternoons: Resident Clinic

<p><i>Urology</i></p> <ul style="list-style-type: none"> • 5 – 6:30 am: Pre-round, get numbers, write notes • 6:30 – 7:30 am: Round with Chief Resident • 7:30 – 6 pm: OR <p style="text-align: center;">Clinic is optional</p>
<p><i>Cardiothoracic</i></p> <ul style="list-style-type: none"> • 4:30 – 6 am: Pre-round • 6 am: Signout • 7 am: Patient huddle • 9 am – 3/6 pm: Floor work then OR • 6 – 7 pm: PM Rounds
<p><i>Transplant</i></p> <ul style="list-style-type: none"> • 7 – 8 am: Pre-round • 8 – 11 am: Pre round with team • 11 - 1 pm: Multidisciplinary rounds • 1 – 5 pm: OR
<p><i>Plastics</i></p> <ul style="list-style-type: none"> • 6:30 - 7:20 am: Meet your patients going to the OR that day, review anatomy for the cases you're going to see, find your team and see if they need anything • 7:20 am – (Variable): OR <p style="text-align: center;">Wednesdays: Grand rounds/M&M; plastic surgery conference (4:30 pm)</p>
<p><i>Gold/Vascular</i></p> <ul style="list-style-type: none"> • 5 – 6 am: Pre round • 6 am: Sign-out • 6:15 – 7 am: Rounding • 7 – 7:30 am: Write notes • 7:30 – 5 pm: OR/Endovascular Suite (Fistulas, EVAR, CEA) <p style="text-align: center;">Vascular clinic one day a week and general surgery clinic one day a week</p>
<p><i>Ortho & ENT</i></p> <ul style="list-style-type: none"> • See Appendix for detailed schedule

ADVICE:

- Always, always eat breakfast or you will feel faint in surgery and have to break scrub
- Read about the case before you get there. The last clinic note is a good place to start
- Pay attention to the relevant anatomy: it is an easy question for attendings to go after.

What resources should I use for the shelf exam?

- Pestana
- NMS
- UWorld

Inpatient Medicine Clinical Site Comparison				
Location	Hillcrest	VA	Scripps Mercy	Scripps Green
Hours	6 am – 5 pm	6 am – 5 pm	6 am – 3pm	6 am – 6 pm
Call	Q5	Q4	Q5	Q3
Pro	Interesting pathology Lots of infectious disease	Bread and butter cases More autonomy Lots of teaching	Easier hours Free lunches	Bread and butter cases Great teaching Free lunches
Con	Less bread and butter cases Less autonomy	Less variety	Paper charts Often forgotten about	Paper charts Less interesting pathology
Dress	Professional. Usually wear scrubs on long-call days			

Typical Medicine Schedule:

- Pre-round on patients and write progress notes
- Morning report
- Rounds with attending
- Finish progress notes/consults/gather information
- Lunch/Noon Conference
- Admit patients, help residents, manage patients, etc.

What is the call schedule like?

- On Medicine rotation, there is no overnight call. Call on medicine is split into short and long call days and everyone is on a rotating schedule. During this time, you are available to admit new patients onto your service. Below is the call schedule for the various locations:
- VA: Long-call every 4 days
 - Short call: Admit patients until 4 pm
 - Long call: Admit patients until 6 pm
- Hillcrest: Long-call every 5 days
 - Short call: Admit patients until 4 pm
 - Long call: Admit patients until 7 pm

Outpatient Medicine recommendations?

- Infectious disease (HIV Owen’s Clinic)
- MSK clinic
- Cardiology clinic
- Endocrine

Advice before starting inpatient medicine?

- **Take advantage of your time on outpatient to study for the shelf exam**
- Review most common admissions like pneumonia, heart failure exacerbation, cirrhosis, ACS, cellulitis, etc.
- Be proactive in asking about consults, putting in orders, procedures, etc.
- **ACT AS THE PRIMARY PROVIDER FOR YOUR PATIENT!**
- **KNOW YOUR PATIENT!**
- **ALWAYS BE CONFIDENT IN YOUR ASSESSMENT AND PLAN**, even though more than half the time you are probably wrong!

What items should you carry in your white coat?

- Stethoscope
- Pens
- Penlight
- Scratch paper

What resources should I use for the shelf exam?

- Step Up To Medicine
- MKSAP
- UWorld

Psychiatry Clinical Site Comparison					
Location	West Wing	SBH/Consult	Navy	VA 2-South/ADTP	VA PEC/2-South
Hours	7 am – 4 pm	7 am – 6 pm	7 am – 5 pm	8 am – 5 pm	8 am – 5 pm
Call	Overnight	Overnight	None	6 pm – Midnight	6 pm – Midnight
Pro	Wide variety of patients with significant pathology Nice hours Follow your own patients	Consult: become good at diagnosis SBH: More comfortable with geriatric population	Good experience Autonomy Didactics with Navy	Less stress More teaching Strong PTSD and substance abuse exposure	Faster paced
Con	Boring after rounds See less patients than consult	Long rounds Longer hours More fast-paced	Less variety	Fewer female patients Less variety CPRS	Less variety CPRS
Dress	Professional				

What is overnight call like at Hillcrest?

- When you take overnight call, you are acting as the consult team for all psych patients that come through the ED. When there is a new patient, the resident will usually ask you to go see the patient, take a history and write an H&P. While technically supposed to be overnight call, most psych residents allow you to go to sleep early, but no guarantees.

What can I expect my daily psychiatry schedule to be like?

Typical schedule during psychiatry rotation:

- Prerounding: 7 – 8:30 am
- Interdisciplinary Rounds: 8:30 – 11 am
- Finish notes: 11 am – 12 pm
- Lunch: 12 – 1 pm
- New admits, teaching, following up on patients: 1 – 5 pm

More specific rotation schedules based on clinical site are below. However, please remember these schedules are just examples and actual schedules are highly team dependent.

West Wing (Hillcrest)

- 7:15 – 8 am: Pre-rounding
- 8 – 8:30 am: Sign Out
- 8:30 – 9:30 am: Finish pre-rounding
- 9:30 – 11:00 am: Interdisciplinary Rounds (times are highly variable)
- 12 – 1 pm: Lunch
- 1 – 4 pm: New admits, teaching/conferences, hanging out, following up with patients

CAPS (Child Psych; Rady's)

- Arrive between 8 – 8:30 am
- Generally follow the fellows around to see patients and then go to rounds. Offer to help the fellows, but often you are just shadowing them.
- Afternoon can be spent in family meetings or small groups. Usually leave in early afternoon.

ADTP (VA)

- No prerounding
- Rounds: 8 am
- Rest of day involved seeing patients that needed to be seen and writing notes on them
- Wednesdays: ADTP conference with Dr. Shuckit. All ADTP medical students, residents and attendings go to conference and observe an intake interview. Then there are case discussion and medical students spend additional time with Dr. Shuckit.

Senior Behavioral Health (Hillcrest)

- 7:30 – 8:30 am: Pre-round
- 8:30 - 9 am: Community meeting
- 9 – 11 am: Inter-professional rounds (Monday, Wednesday, Friday). On non-rounding days, would discuss patients with residents. Occasionally will attend ECT.
- 12 – 1 pm: Lunch
- 1 – 5 pm: New admits, mingle with patients, write notes, and afternoon meetings

Consult (Hillcrest)

- 7:15 – 8 am: Pre-round
- 8 – 8:30 am: Sign Out
- 8:30 – 11:30: Round on ED and floor patients (times are highly variable)
- 11:30 – 6 pm: New ED and floor consults

VA Urgent Clinic

- 8 am – 9 am: Morning rounds
- 9 am – 5 pm: See patients. Each encounter involves meeting with the patient for 30-45 minutes and then staffing with attending. The assessment and plan is then discussed with attending and patient.

2-South (VA)

- 7 – 8 am: Pre-round and write progress note
- 8 – 10 am: Inter-professional rounds. Monday, Wednesday, Fridays there is ECT from 9 – 10 am in the PACU.
- 10 am – 12 pm: Finish notes
- 12 – 1 pm: Lunch
- 1 – 4 pm: New admissions, teaching, helping residents, talking to patients

Navy

- 6:30 – 7 am: Pre-round
- 7am: Sign out
- 8 am – 4:30 pm: See patients with attendings and residents, new admissions

Advice before starting Psychiatry rotation:

- Don't expect it to be really easy with no work
- Don't be scared of the patients. You can learn a lot from them.
- Start learning drugs early
- Learn the different dispositions and hold statuses
- Talk to the staff and social workers

What items should you carry in your white coat?

- Good one. In general, psychiatry recommends against wearing a white coat, but may want to check with your team beforehand.

What resources should I use for the shelf exam?

- First Aid for Psych
- Casefiles
- Lange
- Psych lectures from MBB

Primary Care Clerkship

Preceptor: Similar to other rotations, selection of your preceptor will be based on a lottery system unless you request to work with your ACA preceptor. Preceptors are family medicine, internal medicine or pediatric physicians.

Schedule: You will visit your preceptor's clinic the same day every week, either Tuesday or Friday, during the entire third year of medical school. Only exception to this is during the 2 months of your surgical clerkship when you are excused from PCC and do not attend. **You DO attend preceptor clinics during surgery selectives.**

*Having a family medicine physician for PCC will meet the primary care requirement for 4th year, but does not make a huge difference. *

PCC Seminars: Once per month, you will meet in your small PCC groups on campus for a seminar to discuss an important primary care topic. This is in lieu of going to clinic. Various readings will be assigned prior to these sessions and sessions will include standardized patients, practice cases, interactive modules, etc.

RATS: At the beginning of every PCC seminar, there will be a short, 5-question quiz on the required readings for the week. The scores on the quiz will contribute to a small portion of your overall grade.

CPA: There are 2 separate standardized clinical encounters in the Professional Development Center as part of the primary care clerkship during the year. These are **not graded** and are simply used to improve your clinical skills. These are very similar to OSCEs, but only difference is that you will be asked to write a note after the patient encounter.

PCC Final Exam: This exam consists of 100 questions with an allotted time of 2 hours. The exam covers the various topics in the required readings and other primary care topics learned through clinical exposures.

Section 3: General 3rd Year Advice and Do's/Dont's

If you could start 3rd year over again, is there anything you would do differently? Is there anything you wish you knew before the beginning of 3rd year?

BE CONFIDENT!
"Make more of an effort to spend time with my patients! It is so easy during down time to get bored or just mindlessly study, but I wish I would have gotten to know some of my patients more. One piece of advice that really stuck was how a resident at the end of every day spent 5 minutes with a patient talking about non-medical things to get to know them better and to remind herself of why he is doing this job and working so hard."
I wish I was more efficient at writing notes.
"I would try to get into the mind-set of thinking that I was the only provider for my patients and that what I did or thought about their conditions was the final decision."
Learn to anticipate and enjoy pimping questions
Be sure to ask residents about their expectations up front for presentations, rounding, etc.
Read relevant information about your patient each night
Develop a more organized studying plan
Learning how to excuse myself early from the wards to not just sit around wasting time

Common concerns beginning 3rd year

Not knowing how to present a patient
Looking stupid in front of the team
Having mean teams that make fun of you for your presentations or lack of knowledge
Not knowing enough and not being able to take care of patients
Early mornings and long hours
Finding answers to questions without needing to constantly ask
Expectations of a 3rd year medical student

What does this mean? You are not alone as you start 3rd year. Everyone is in the same boat with plenty of concerns and anxiety. However, as you will find out, you adjust and pick up information very quickly. Especially during the start of 3rd year, most people have

little expectations for medical students, so use this opportunity to get comfortable. The most important thing is showing up on time, being enthusiastic and caring about your own learning! Do these 3 things and everything else will fall into place.

Fitting in with the team (attendings, residents, other students, etc.)

<i>DO</i>	<i>DONT</i>
Always be on time	Don't be arrogant
Be excited about taking on challenging cases	Appear to be bored or be on your phone during rounds
Offer to help by paging consulting teams, nurses, etc. (especially as you advance in the year)	Directly ask to go home or ask your resident if you are tired
Ask questions when you do not understand something	Answer another medical student or resident's question on rounds unless it is addressed to you
Come up with your own assessment and plan for patients each day even if it is totally wrong	Throw other medical students or residents under the bus
Go over your plan with intern or resident	Be afraid to ask questions at the right time
Let other medical students know if you plan on doing a presentation	
Read about your patients	
Leave if they say you can!	

Note Writing

<i>DO</i>	<i>DONT</i>
Write too much! It is better than not enough.	Copy and paste old information without updating
Create a wide differential diagnosis	Copy and paste assessment and plan from resident's notes
Get note templates as early as possible	Leave the A/P blank
Ask for feedback from your interns	

Down Time

<i>DO</i>	<i>DONT</i>
Check up on your patients and report back to your residents with updates	Disappear without telling your team

Study	Constantly badger your residents
Eat	Don't forget to spend time with the people and community you love
Work on presentations you have to give on rounds	Don't stop doing the things you enjoy

<i>Team interaction</i>	
<i>DO</i>	<i>DONT</i>
Be part of the group. It is ok to be a part of the conversation.	Do not talk poorly of other students, residents or attendings, even if your team is
Be comfortable being yourself and joking with your residents, while maintaining a respectful and professional relationship	Isolate yourself
Anticipate things they may need help with	Be weird

<i>Dress</i>	
<i>DO</i>	<i>DONT</i>
When in doubt, err on the side of professional	Don't look like you shouldn't belong in a hospital taking care of patients
Dress like the rest of the team	
Wear comfortable, closed-toe shoes	
Wear your white coat if the team does	

Appendix: Specific Surgery Schedules

Burn Surgery

Schedule:

Monday, Wednesday, Friday - Round: 7 am; OR cases after

Tuesday - Round: 8 am; really nothing to do after

Thursday - Round: 8 am; clinic from 1-4 pm (3rd floor)

Weekend - go in one day at round at 8 am. Then you are done.

Trauma call - 6 pm to 6 am the next day. Then you round the next morning and then you go home. Just make sure to let your resident know you are post-call, so they let you go.

On Monday, Wednesday Friday, you go until all the cases are finished. I would say usually around 5. On Tuesday, you are basically done around 10 with little to nothing to do afterward. Thursday, you are done after clinic. As for when you are allowed to leave, it is all resident dependent. If you are just sitting around with nothing to do, ask the resident if there is anything you can help with (hopefully that gives them the clue that they should let you go). They have a tendency to just forget about letting you leave.

Attire: Scrubs...white coat is not necessary, except for clinic. You get your scrubs from the second floor OR near the men's locker room. At the scrub machine it asks for your ID# and then Pin or something like that. You just type in Your Code + E twice and that will dispense your scrubs.

Codes:

Main Burn ICU door: 543

Floor - ICU back door (you will figure out what I mean): 25enter

Physicians lounge (next to ICU entrance): 143

Resident work room (for trauma call): 145

Trauma bay: 642#

Rounding:

So it will probably take you about an hour (maybe a bit more in the beginning) to round on your patients. Start off with like one patient and then work your way up. It is expected that the NP, interns and medical students see all the floor patients. If you have never rounded before, just let him know and have him start you off simple and build your way up. Just make sure to verbalize that. As for rounding, it is pretty simple. You just ask them pretty basic questions: any problems overnight, N/V, last bowel movement, eating adequately, urinating fine, pain level, etc.) In addition, I usually read the nurses notes and any other people that wrote notes for the patient. I also usually check in with the nurse that was there overnight to make sure I don't miss anything. Then you sit around in a circle around the attending and present your note.

As for the note, super simple (the note needs to be done before rounds): basically just go to the last progress note for burn, press the copy button and change the information as needed. *****MAKE SURE TO UPDATE EVERYTHING THOUGH! IT IS DANGEROUS TO COPY BECAUSE YOU CAN FORGET TO UPDATE CERTAIN INFORMATION...SO JUST BE CAREFUL!***** Once you finish the note, you click Share (never sign!). Once it is shared, you can always go back and edit it.

Presentation Say one liner "pt with % TBSA burn" who is post burn day ___ Their overnight events were ____ Vitals: afebrile, hemodynamically stable--> Their exam was unchanged from before. Burn still is in (___ Santyl or PSO) their labs came back in normal ranges, Pain is controlled on oxycodone, Assessment and plan is to continue to monitor burn and treat with clean dressing changes yada yada. You are supposed to go by systems but most of the systems will be "stable." Just read off the note and you will get all of this. Eventually they will prefer it if you present them in under 2 minutes, because we aren't doing much for floor patients. I usually would print out the notes (2 pages per sheet) before presenting.

Lunch: Grabbing lunch is usually not a problem. You can tell the team if you want or you can just disappear and go grab lunch...don't think it matters. For surgery days, grab lunch in between cases. On Tuesday and Thursday, you have time.

Things To Do To Help: Surgery brief op note and discharge summary template. Much easier to show in person. Just ask the resident to demonstrate once.

Education Thursday Presentation: The last Thursday of your rotation you have to present any topic of your choosing related to burns. It is like 10-15 minutes and very chill. People are just sitting around listening. Nothing really to worry about. Also, usually every Thursday, someone will give a small little lecture at 11 am at the nurses station.

HALASZ (VA)

Attendings:

- Dr. Cosman (colorectal/champion for Halasz)
- Dr. Ardill (chair of Halazs)
- Dr. Bouvet
- Dr. Kelly (super interesting cases)
- Dr. Sandler (laparoscopic)

Your Team:

- Chief Resident PGY5
- Senior Resident PGY4
- Junior Resident PGY3
- Intern PGY1
- Two med students

Logistics

For the most part, you'll mostly be in the fifth floor (5W:OR; 5S: DOU/PACU/ICU; 5N:ASU; 5S: med/surg). The only other places you'll be will be Area 2 (first floor of VA) for clinic, radiology conference room on the first floor, pathology conference in path lab, and med/surg on 3North

ICU door code: 1985 bottom rt corner

OR door code: 1234 bottom rt corner

Resident workroom: 5196 bottom rt corner or 5193 bottom rt corner

Image viewing room: the code is the number of the room

Parking: Park in 6th college and walked through the basement of the VA (through the warehouse).

Call Schedule: One Friday night per month (coordinate with CT and Vascular)

Typical Day:

4:45-5:15 am - arrive at VA

5:15-6:00 am - grab numbers/pre-round

- numbers to get:
 - For ICU/DOU patients:
 - Lab values (Chem10, CBC, Coag studies when applicable)
 - If any abnormal, put in parenthesis the day before's
 - These numbers should be in CPRS by the time you get there at around 5 am
 - Vitals: (you have to go bedside to get these vitals for ICU/DOU pts)
 - Temperature: T-current/T-max
 - HR: Range
 - BP: Range
 - RR: Range
 - O2 Sat: Range + type of oxygenation (RA [room air], 2L NC, etc.)
 - If applicable, ventilator settings
 - Tidal volume/FiO2/Rate/PEEP
 - ex. 500/50/12/5.0
 - Ins and Outs
 - Found at bedside
 - Nurse will have it totaled in the chart; sometimes, if you come too early, it may not be done
 - Make sure for the Ins, you put a subheading and specify what ins they got, especially for PO
 - For Outs, make subdivisions as well for everything (i.e. UOP [urine output], CT [chest tube], NG, JP, etc)
 - For floor patients:
 - Lab values do not get in until around 7 am. Just put abnormal from the day before in parenthesis
 - Vitals - organized the same as above but these can be found under the "cover" sheet at the bottom of the CPRS patient chart.
 - Ins/Outs - Nurse records ins/outs and writes them into the CPRS chart as a nurse note. It's titled something like "nurse 24 hr/ins and outs"

6:00-6:30 am - formal sign-out at conference room

- There is usually a person that does a 5 minute lecture on some high yield topic. You'll get assigned a couple of days.
- 6:30-7:00 am - rounds with team
- There is a bag that I like to call the Indiana Jones bag. It has a bunch of supplies in it that are useful for bedside procedures such as dressing changes. It is usually located in the far corner of the room that has the passcode 5196.

7:00-8:30 am - huddle in ASU/write notes/bird-dog for team

- bird-dog: after huddling, you sit there in the ASU working on your notes. When the patient starts to get rolled to the OR from the ASU, you text the rest of the team and let them know that the patient is rolling

rest of the day - OR/write notes/check on patients/updating list/consults/etc.
Sometime in the afternoon - afternoon rounds
6:00-8:30 pm - end
Lunch break: Usually eat lunch while working on stuff

Monday

8-1 pm: OR
1-5 pm: General Surgery Clinic
5ish: Afternoon rounds

Tuesday 1-5 pm

8-1 pm: OR
1-5 pm: Vascular Clinic
4-5 pm: Tumor board
5-6 pm: VA M&M
6: Afternoon rounds

Wednesday (no formal sign-out on Wednesdays b/c of UCSD m&m)

~6am: Rounds
12-1: Halazs weekly pre-op meeting
1-5 pm: General Surgery Clinic
5ish: Afternoon rounds

Thursday

8-5 pm: OR
8-12 pm: Colonoscopies
4-5 pm: Pathology conference
5ish: Afternoon rounds

Friday

8-5 pm: OR
8-12 pm: Colonoscopies
5ish: Afternoon rounds

Tips:

- When pre-rounding on your patients, there are some things you should definitely do:
 - Check their lines. Sometimes the list isn't correct so you need to check what lines they have in as well as any gtts (drips) they have going
 - Ask if they have flatus (gas) or BM: indicators of returned bowel function. This is important for knowing when to advance their diet.
 - Ask for any nausea/vomiting on their current diet: super important when you're advancing their diet. If advancing diet slowly, usually goes NPO->sips->Clear Liquid Diet (CLD) "clears" w/ or w/o limits->Full Liquid Diet (FLD) "fills"-> Regular.
 - Ask about pain control
 - Ask about ambulation
 - Any other questions/concerns
 - FOCUSED physical exam on their abdomen or area of operation
- When presenting your patients, get a feel for how your chief likes them presented. Usually for surgery, you do NOT want super long presentations. <2 minutes is good. Heck, if the patient isn't all that complicated, less than 30 seconds might be even better. It's really a matter of what your chief wants. Mention any acute overnight events and the aforementioned things that you checked on your patient. Then suggest an assessment/plan.

- When in the OR: read SURGICAL RECALL beforehand. MORE IMPORTANTLY, go to google and look at the anatomy of whatever you're about to dissect and the anatomy of the things you'll go through to get to that thing. You'll get pimped on anatomy more than anything. Definitely know Scarpa's fascia. I've been asked to identify it on multiple occasions.

Trauma Call (Hillcrest)

1. Get to Hillcrest by 6PM for trauma sign-out (where day team transfers the pt to night team)
2. Go to the General Surgery Work Room directly across from the Trauma/SICU on the 2nd floor. Door code = 145
2. Introduce yourself (just good to do to get know folks and they know you.)
3. Connect/Check in with those in charge of the night team (I would ask the intern to give you a breakdown of what to do when there is a trauma call; really helps)
4. Ask what you can do during the night
5. Use the phone to put yourself on the Trauma call list. Dial 0, tell operator you want to be put on the trauma call list.
6. Respond to all trauma calls. Report to Trauma Bay across the hall and the second door. Door code 642# (red light keypad). Trauma Bay can be accessed from a variety of places and same code works on all doors.
7. When in the Trauma Bay, get gowned with the lead protective covering (in middle area on wall), yellow gowns (near the back on shelves), gloves, foot booties if you don't want blood on your shoes. You will see others doing this so you will know where to find them. If not, ASK!!
8. Role of med student in trauma bay = Get 4 blankets and lay them on left lower corner of the bed. Cut off patient clothes (pt will be completely unclothed). Ask how you can help. If something looks like you could help out, go and ask. You may be asked to write the H&P - there is a template on the computers in the bay. Just pull it up and fill it in as others ask the patient questions.
9. Use your time wisely so try to read up on patients or read clerkship books.
10. EAT/BUY DINNER BEFORE YOU START!!
11. Ask questions! :)
12. You can also help in the Trauma Bay with assisting in fem sticks (insertion, or pulling blood in the syringe), sutures, Foleys if they give you the chance.
13. Note the pts that come in during the night that you have interest in. You can ask to follow them in the morning during sign out.
14. Where to sleep: there are couches in the resident workroom, or if you can get back in time, the medical student on-call sleeping rooms in the West Wing.

Trauma Rotation (Hillcrest)

1. Punctuality of course
2. Usually meet in General Surg Work Room located across from SICU/Trauma for sign in at 6AM. **Door code is 145.**
3. Meet there also for sign out of Trauma night team (handing pts over to day team) at 6PM.
4. Listen and take notes on patients that they talk about them to be aware of all the pts everyone is seeing. So you know what is going on the floor and can help out with info.
5. Be proactive in getting assigned two patients if you haven't been assigned already. These are the floor pts. You may be given SICU pts later in the rotation.

6. Pre-round on pts early (4:30AM) and try to write your note early as well or when they tell you to have it done. This will be crazy the 1st day but you will get the hang of it. The fellow said her expectation is for you to be here at 6AM but I had to be there earlier to get things done.
7. When asked to do a small presentation on info. Make it good! Know your stuff. You are not given an exact time as to when you will present the info. When asked to do a presentation: I usually look-up the the topic on Wikipedia first to get a general idea, then go to uptodate and some articles to confirm.
8. Ask questions BUT not during presentations. It is best to do that after.
9. Ask what things you can do to make work more efficient for interns and residents.
10. Always attend rounds (both floor and ICU). ICU has rounds in the mornings and afternoons. Usually 9:00AM and 3:00PM. Ask your residents to make sure.
11. Read up on the conditions of your patients. You learn better that way.
12. Read up on anything attendings or anyone else on the team tells you to read about if you can.
13. Practice presentations before hand. Helps with 1st impressions.
14. Any procedures that are going on during trauma: watch then ask to do it the next time if not offered. Get ready to do Foleys and Fem Sticks.
15. Read Trauma sections of any book you are using (NMS Casebook/Surg Recall, etc) BEFORE the rotation. BEFORE the rotation. BEFORE the rotation! Helps a lot because you can more actively participate in discussion.
17. Have an idea before day one of how you will prep for rounds and present during rounds. Surg recall has a nice outline in the front. Ask the interns for help on this the first day.
18. Follow your pts in the morning and afternoon to keep up with what is going on with them throughout the day.
19. During rounds, this is how you present (also I'm sure one of the residents will help. Just ask):
 1. Start with pt identification + reason for being in SICU
 2. Go over anything that happened overnight.
 3. Review Lines (all the catheters, IV, chest tubes, etc)
 4. Review Meds (what is currently being used, what was taken the night before)
 5. Record vital signs in a range rather than measurement of the current day.
 5. Begin the Systems Review, each with plan.
Neuro, Toxicology, CV, Respiratory, FEN/GI, Renal, Heme, ID, Endo.
 6. End with discharge plan
 7. Try to review your note and presentation with a resident before rounds if possible but they are often very busy, so this often doesn't happen.
20. Your job during rounds to be catch orders, which basically means you listen out for plan and each pt and record it so that you can help residents if they forgot anything. Easiest way is to create a checklist on a separate sheet of paper.
21. Try to be excited and enthusiastic. It can really help since the environment can at times be really tense. Don't let the environment affect your mood and try not to take things personally.

CT SURGERY

Attendings: Dr. Coletta and Dr. Gramins

Team: Fellow (sometimes), resident (PGY1/2), medical student

Call Schedule: One Friday night per month (coordinate with Halazs and Vascular)

Logistics

ICU door code: 1985 bottom rt corner

OR door code: 1234 bottom rt corner

Resident workroom: 5196 bottom rt corner or 5193 bottom rt corner

Image viewing room: the code is the number of the room

Typical Day:

4:45-5:15 am - arrive at VA

5:15-6:00 am - grab numbers

6:00-6:30 am - formal sign-out at conference room

6:30-7:00 am - pre-round with resident

7:00-7:20 am - huddle in ASU

7:20-8:00 am - round with attending(s)

8:00-8:30 am - work on notes while resident works on orders

8:30-rest of the day - OR/write notes/write discharge summaries/check on patients/updating list

5:30-8:30 pm

Lunch break: Usually eat lunch while working on stuff

What you do in the OR:

- Lots of observing; know the anatomy of the heart/thoracic cavity
- During the first part of CABG procedures, Matt DeVries (the PA) works on the leg while Dr. Coletta/Gramins works on the chest. Matt lets you close the leg with deep dermal -> sub-cutaneous stitches.
- After I had seen each procedure at least one or two times the whole way through, I stopped staying for the entire thing and would scrub out and manage the patients on the floor.
- Talk to Jon, the perfusionist, about the perfusion machine. It's pretty cool and interested stuff to know.

Tips:

- Try to present as many patients as you can during rounds. Ask your resident if you can present some. I would recommend starting with floor patients then working your way up to ICU patients by the second week or so. Take charge of these patients. Know their chart inside and out.
- When presenting patients, Dr. Gramins likes the system approach, so present your patient's overnight and assessment/plan as such:
 - Neuro
 - Cardio
 - Pulm
 - Etcetcetc
 -

Sign out from night float at 6AM, 1 person will do a quick teaching session each morning, the chief will assign at the beginning of the week, should last about 5 minutes. I did pancreatic ca, others have done HCC, SBO, peripheral vascular dz etc.

Schedule: Clinic is on Wednesday, I was never able to go since we had teaching so I have no advice for that. I would recommend looking at an H&P from one of your surgical patients to see what they want in clinic - obvi the normal stuff, PMH, PSH, the meds they are truly taking is really important bc we base their inpt meds on those, smoking, drinking, exercise

tolerance etc. Other than that, you are in the OR most days. I think there were only 3 days during my month when we didn't have cases.

"Huddle" is at 7AM in the PACU in the "Venice" bay - you will huddle around the pt that is going to the OR that day with the team, anesthesia and the nurses. Basically the OR debrief but it is always done at 7 in the PACU.

Important people:

Matt is the PA. He will do the saphenous vein dissection for CABGs and will help come and close if it is before/close to 3pm, that is when he is off.

John is the transfusionist, runs the heart/lung machine. He is awesome, totally open to teaching and will answer any questions you have. Get him to give you a primer about how the machine works at some point.

Dennis and Chad are scrub techs that are SO fun and awesome. Get them to teach you to gown/glove independently at first. They're so fun.

Responsibilities:

So here is what I would do while on the service. You can adjust however you and Michelle decide. I would arrive between 4:45 and 5, depending on how many patients we had and update the list and get all the patient's vitals/labs before sign out. Sometimes we would round with Z before huddle, sometimes we would round after. Then I would help Michelle with some of the floor work (pulling wires or CT), write a note or two then head to the OR. If there was nothing to do I would go straight to the OR. After surgery, walk with the pt to the ICU then if Michelle had not added the new pt to the list, I would do that. Need to find their meds, PMH, Hgb A1C from their H&P and old labs. I also did all of the discharge summaries. Michelle does not want you to

For the list: ICU and DOU patients you have to get their vitals from the paper chart at their bedside. Labs are in CPRS. For floor patients their vitals are in CPRS. Their labs won't result until after rounds but ICU and DOU will have labs drawn early.

For ICU pts - you want to get their vitals, last 3 urine outputs, last 3 CT outputs, recent ABG, vent settings, glucose range, insulin required, I/Os. The nurses in the ICU are SO good, and super nice and will help you a lot. I learned a ton from them also. Figuring out what they want on the list and how to get the numbers took me like a week to get a hold of.

In the OR:

For CABG - Matt will dissect the leg and then you can close those incisions. usually 2 deep dermal interrupted then a sub-cuticular stitch. they will teach you on the first day. After dealing with the leg, you need to scrub out and scrub back in to go back to the chest. At this point I would usually step out and eat/pee for 15 mins. This would be a time when you could go see what is happening on the floor if you wanted to avoid the OR probably. Then I would go back in and watch the rest of the case. They will let you close the skin on the chest also.

You will mostly see CABG and AVR, sometimes mitral valve replacements, maze procedures, aortic root replacement, some lung stuff (VATS) etc.

Post-op care:

Patients will remain intubated usually until POD1 depending on their status. They manage MAPs with Dopa, Epi, Neo (phenyephrine), Vaso, Nipride and usually try to keep them around 65-75. They will get Lasix starting at 5AM on pod1 and they will sort of monitor and adjust that as needed. Once they are extubated you can restart baby aspirin on day one and their home statin. You will slowly add their home meds back on, usually a metoprolol on day 2 then maybe an ACEi if they have room. Insulin control is really important (goal less than 200) so they will stay on an insulin drip for two days then transition to glargine and SSI. Initial pain management is a Fentanyl drip then once they can tolerate PO they can switch to oral oxy or percocet. They dose the glargine at half of the 24 hour dose of insulin drip. You will pick all this up as you see it, not trying to confuse you but here are at least some guidelines.

Chest tubes usually come out day 2 or 3 depending on their output, needs to be less than 200 in 24 hours. Pull pacing wires first, then watch output and pull CT 30 minutes later if there isn't a huge output. Michelle will teach you how.

Wound vacs can come off before discharge. They usually move to the floor around day 4-6 depending on how they are doing.

Dr. Coletta will give you a great hemodynamics talk that will really help clarify how they manage the drips. Try to get it early in the rotation, or Michelle could give it to you.

Also, Dr Coletta does lung procurements/ transplants so if you are interested in going, let her know and she will call you. It's a cool experience bc you get to do a lot of the operation.

Head & Neck Service

Overall: Most people are very very nice, pre-rounding and rounding is optional, there's a lot of diff things to see, and the schedule is super flexible.

Schedule: YOU are in control of your schedule! There are various ORs and clinics on diff days of the week. Attached is a rough calendar of which attending has clinic and OR when. I've added a column with what 'code' in EPIC you should log into to view the clinics - it'll either be PMC HNS, MUC ONC, or MON HNS. Nobody takes roll, you don't have to tell people beforehand, you just show up :). Only thing is to coordinate with the other medical students so people don't show up at the same place. Weekends are off! No call either.

Every other Friday from 7-12ish is Grand Rounds at MET.

Attendings: In general everyone was easy to get along with, good teachers, happy to answer questions, and no terribly scarring pimping. A very nice bunch.

EPIC: To view the clinics, use the codes mentioned above, then select the attending. To view the surgeries, hit the Epic tab (top left) --> surgery --> Master daily schedule --> look at Hillcrest OR and Hillcrest OSC (outpatient) for the next day. Usually what I did is the night before, I'd check the clinics and surgeries scheduled for the next day and decide what I thought sounded cool. I would read up on the patient and type of surgery a little. And then I would show up there the next day. Simple as that.

Note writing: If they ask you, you can just write a note for the patient's you see in clinic. The only attendings I wrote notes for were Watson (she'll give you a template), Weisman, Husseman and Coffey.

Surgery: There were tons of cool surgeries, as you can imagine. I recommend watching the neck dissections. Really cool anatomy and wide open. You will be retracting and suctioning, maybe suturing but only if you ask. I didn't get as much out of any that end w/ '-oscopy' b/c that meant they put a scope down, and honestly you can't help out with much there. My favorites were the **neck dissections and thyroidectomies**; there was a lot of anatomy to be appreciated. A lot of the laryngoscope and tonsillectomies weren't as high yield b/c if they didn't attach a camera, you really couldn't see or assist w/ anything. Feel free to ask the residents and they can also tell you what surgeries let you see the most.

There's no way to preview the surgeries in the VA the night before, so you can email whoever the resident is at the VA the day before asking if there are cases you can come in for.

Also, spend at least 1 day at Rady's - you just show up. They have scrubs for use in the breakroom, ENT ORs are 3 and 4

Clinic: depending on the clinic, you'll be taking a quick history of the patient, then presenting it to the attending, and maybe writing the progress note afterwards. Wear a white coat. The nurses for each clinic are extremely friendly and knowledgeable, so don't be afraid to ask them to guide you.

Procedure: in clinic after you see one, ask to do one (eg laryngoscopes). In the OR, you can be second assist in longer surgeries when it's busy.

Neurosurgery

General Advice:

1. Show interest – the residents are all really nice people, but fitting with their stereotypes, they all have egos. Show interest in their specialty and you'll have a better month on neurosurg.
2. Don't be weird – true for every rotation, or so I've heard, but I think especially for surgical rotations. They aren't going to evaluate you for your surgical knot-tying abilities but rather on your ability to fit in with the team.
3. Be prepared for long hours – There are sometimes scheduled procedures that start at 5pm or later, which means you may be there most of the night. I asked to leave once at 11pm and my chief resident was fine with it, but it probably depends on the case and the day.
4. Scrubbing in – I did not get to do much for the first two weeks, but after they got to know me I was a little more aggressive about asking to scrub in. You may scrub in and do nothing, but it will show you want to be in there and you will get a better view
5. ICU presentations – be quick, don't worry about not saying some things. They will ask for certain lab values if they want it, so have them available. The goal is less than 1 minute, but it depends on the complexity of the patient. Don't try to make a patient more complex than they are

6. Patients – pick up one patient at the beginning. I saw 1 patient for 1.5 weeks until I was comfortable with my presentation. If you're comfortable, you won't slow them down, which the team will appreciate
7. Easy ways to help the intern
 - a. Draw CSF – very easy, the residents will show you how on day 1 most likely. You will need a 10cc syringe, betadine prep, gloves, a red cap, and 2 patient info stickers from their chart
 - b. Pull an EVD – only do it if you are comfortable. Watch 1, do 1. Cut the suture tying down the EVD, pull the tube (there should be almost no tension, if there is tension, stop), and then throw a figure 8 knot. No lidocaine is used. You will need sterile gloves, chloraprep x 2, suture removal kit, needle driver, 2.0 sutures

Full ICU presentation outline:

-One Liner: Name, Age, gender, what happened to them (*I gave a full one-liner my first couple times for a patient and then switched to just name, age, gender*)

-Post-op Day X, Procedure (*important!*)

-Staples come out on POD14

-Sutures come out typically around POD7, but this varies by location. If you ask to clarify, it shows you are paying attention

-Lumbar drains stay in for 3-5 days, recommend a clamp trial for 24 hours before removing

-Overnight Events: this doesn't include events such as the patient was in pain. It does include desats, ICP spikes, fevers, etc.

-Lines/Drips/Drains: I include this in my note, but don't say them.

Objective by System:

-Neuro: there is a different exam for the awake patient and the comatose patient

Awake

Wound or incision clear/dry/intact

Trached (some patients are awake and oriented but trached and on a ventilator. State this, because these patients are non-verbal, which means their GCS is down)

A+Ox3

PERRL, EOMI

CN exam – rattle quickly what you did (*my recs on what to report are PERRL, EOMI, face symmetric, tongue midline – this gives a CN at each level of the brainstem*)

Motor – strength 5/5 throughout vs. strength baseline 4/5 on LUE

Pronator drift – *report if they have reason to have motor problems*

Sensory – *rarely reported*

Reflexes – *rarely reported*

Coma

Eyes closed

Intubated, sedated on _____ (*always state their level of sedation, for example, 125 of Fentanyl and 30 of propofol*)

Eyes – open spontaneously vs. to voice vs. to tactile vs. to noxious stim vs. don't open

PERRL, eyes track vs. eyes don't track

Corneals, cough/gag, doll's eyes – not done by 3rd year students but you can ask the resident to check for you if you think it is important

Motor: spontaneous movement vs. "give me a thumbs up" vs. "show me 2 fingers" vs. localizing movement to pain in shoulder (squeeze their trapezius) vs. withdrawal to pain in finger (squeeze their nail) vs. decorticate vs. decerebrate vs. flickers (which

is nothing) vs. triple flexion (spinal cord reflex of stereotyped hip/knee/ankle flexion, worse than withdrawal)

Always start with verbal instructions. Give them a chance to have a better exam, don't rush to noxious stim.

Place the hands at midline when you try to get them to localize (gives them an advantage)

Other neuro:

Intracranial Pressure – very important in ICU patients

Kamino = bolt = a tool that measures ICP

EVD = external ventricular drain = measures ICP and drains CSF from the

ventricles

What to put in your note:

-ICP range + most common numbers (*example: max ICP 15 when patient moved, but mostly stable between 6 and 8. Patients with craniectomies should have ICPs < 10*)

-Drain level: EVD at 0 means it is draining at head height (not against gravity) vs. EVD at 10 means it is draining against 10cm of gravity which means the patient is doing “better”

-Drain output: 220mL in 24hr, 30 in the last 3

-Drain events such as the drain was clamped or clotted and flushed

Management of elevated ICP:

-Head of bed up

-Hyperventilation

-3% hypertonic saline, salt tabs, etc.

-Mannitol

-Sedation also lowers ICP. If you are weaning sedation, monitor ICPs. Propofol and Benzos are GABA agonists --- decreased cerebral metabolism --- decreased ICP

Sodium level +/- trend – as above, hypernatremia is permitted for ICP control

Tell them what sodium they are taking. Salt tabs, hypertonic saline rate

CSF results

-Cardio

Systolic ranges, most common

MAP determines cerebral perfusion pressure (CPP = MAP – ICP)

-Pulm

Satting well on RA vs. Ventilated

Ventilated? Present:

-PEEP + %O₂

-ABG: pH, pCO₂, pO₂

-GI

I never presented this unless they were NPO for a procedure that day

-Renal

Creatinine (+/- trend)

Ins/Outs, Net

They may ask you for the last 3h and for their net since admission, so just have that in your back pocket

-ID

Tmax +/- trend

WBC

Any cultures

Have in note but don't present: Antibiotics, CBC differential

-Heme

Present: Hct, PTT, INR

-Endo

Glucose

Include more for newer patients, but here is an example of a very quick presentation for a patient you have seen multiple times (still have all the info available):

-Ms. Patient is a 39F s/p fall from ladder

-POD5 R craniectomy

-No acute events overnight

-Neuro exam stable. Incision clean, dry, intact. Eyes closed, sedated on 50 propofol, 150 fentanyl. No response to stim, pupils equal and reactive, bilateral uppers localize to pain, bilateral lowers withdrawing. ICPs mostly 15-17 when weaning sedation, bumped up propofol again and ICPs stable at 6-8. EVD at 0, drained 220 overnight. Sodium 151 on 2g salt tabs BID, hypertonic saline at 15

-Systolics stable mostly 120s

-Vented at PEEP 5, FiO2 40. ABG not back this AM

-Creatinine stable at 1.1, had 3.1 in, 3.1 out, for a net even.

-Afebrile, white count 7.9. CSF cultures still no growth, gram negative

-crit stable at 33.7, PTT 40, INR 1.2

-Glucose 110

-Plan today is to continue draining, try weaning sedation as permitted with ICP

HC Ortho Trauma Rotation

Schedule:

Mornings

- You won't preround, but you'll be expected to update the list by the time the intern gets there. We usually arrived around 5am, but there were three of us updating it. Get there early the first few days
- The list (word doc) is on the computer directly in front of you when you walk into resident's room.
- The people on the list are in epic (Shared Lists --> Ortho Trauma Inpatient--**make sure to go to the one that actually has patients on it!**)
- Things to update:
 - **Vitals**
 - **PT** = physical therapy (steps taken and how far)
 - **Wound vac output:** under Input/output (call the nurse if not updated yet)
 - **Room number:** *this changes pretty often. Don't*
 - **New labs:** wbc/hgb/hct/plt; CRP and ESR, INR and PTT,
 - **New imaging:**
 - **Read last ortho notes and overnight**
 - **Meds:** abx, ppx (prophylaxis), Pain, Other
 - Protip: go to "MAR Current" under "patient summary" tab to get the updated meds.
 - **Check any labs or images for follow up**
-
- Double-check which ORs are going and which cases you want to see or what attendings that don't have sub-i's have cases

- Look at the images from any patients from overnight (prep for bone boards-see below)
- **Rounds:**
 - Go get the bucket from the storage room (code 5-3-1), it should have all the dressings and scissors and such. Return it to the cast room so Mike (ortho tech) can replenish it
 - You round as a team, but you can be helpful by doing things to make rounds more efficient
 - know about each patient to remind the chief before he walks in the room
 - Get gloves ready for residents so they don't go searching when they walk in
 - Undo dressings before the team gets there
 - Have the bucket ready and know what is in there (mepelex, curlex, tegaderm, ace, tape, etc)
 - If any tasks get added to the list (listen, it won't always be "add this to the to-do list") then write it down on your copy of the list. By the end of rounds your list should look like the intern's.
 - Once rounds are done, there are always Bone Boards, where the overnight intern presents the patients from overnight and you go through all the relevant imaging as a group.
 - You may get asked to read an X-ray on bone boards, but usually it's the sub-I's that get it. But go through them beforehand anyway so you learn some stuff
- **During the day**
 - Trauma surgery can be busy or slow depending on....how many traumas there are! How often you are in the OR depends on the number of students and the number of ORs going.
 - The night before, read up on all the cases and potentially coordinate with the other students on what cases you want to see (epic --> Master Daily Schedule)
 - If you are scrubbing, go introduce yourself to the scrub nurse and circulator, help out with the patient and getting the room set up
 - Post case, make sure to get the bed and blankets, then help move the patient.
 - Be helpful!
 - *If you aren't scrubbing on a trauma case:*
 - If there are any other orthopedic surgeons that don't have a sub-I you can often go scrub with them (Joints, scopes, spine)
 - try to read about the approach because you'll likely get pimped.
 - Help and see patients in clinic (if there isn't a sub-i)
 - You aren't allowed to write notes, but if you want you can write them in a word doc for practice. You may get lucky and get it used if you tell the attending you are going to write them for practice anyway.
 - Help the intern!
 - Remember those tasks you wrote down during rounds? Now's the time to try and help out with them. For lab f/u and such just check them and report whether they are back or

not. For wound vac changes, ask if you can learn, then offer to do it yourself.

- Follow the intern and just be helpful in general!

- **IR list**
- These patients are in a different color on the word doc list and on a separate shared list in epic (Ortho Trauma IR)
- This is the list of patients who we signed off on but are still in house, but we don't round on everyday
- Round on them Saturday Mornings, so on Friday try and go through and update the IR portion of the list (same as normal list)
- Stay in the room on right in the morning, other room for senior residents
- Random acronyms
 - TTW: toe touch walking
 - FWW: front wheel walker
- NWB- none weight bearing
- WBAT- weight bearing as tolerated

Attending schedule:

Girard: Mon/Tue/Fri OR, Wed/Thurs clinic

Schwartz: Wed/Thurs/Fri OR, Mon/Tue clinic

Bone boards:

Be sure to review how to read XR's before monday bone boards (the section in the MS3 guide to ortho trauma was helpful.. the mnemonic given in the ppt wasn't as useful b/c slightly out of order from how you should talk about XR, but the ppt was useful for visualizing the descriptions). In the AM when you're done updating list, you should also review imaging from previous day/night to prepare for bone boards. While you can view imaging in Epic, the residents prefer using IMPAX (ucsd email login).

OR:

Ortho is usually in OR 3 or 4. Don't forget to put on lead before you scrub in. Otherwise, similar to other surgeries in the OR. Check the OR schedule daily and prepare for next day's cases (relevant anatomy, indications, potential complications, etc). Use orthobullets.com to prepare.

Also, you may get to see OR cases w/ other ortho divisions (spine, hand/UE, foot&ankle, joints). Each of these services have different OR etiquette, but you'll have a lot of fun seeing their surgeries as well. Your chief will usually find other OR cases for you if our trauma team doesn't have enough surgeries scheduled for the day.

You won't be able to do much in the beginning. They have to get to know you and trust you first. By the end of the month, they may let you close, put in screws, remove ex-fixes, etc. Don't push it. If they see you do well (i.e. in bone boards, good presentation, etc.), then they'll want to give you more time w/ power tools. See it as a privilege to earn power tool time! :)

Consults/Clinic:

If there aren't enough cases for you both to be in the OR, one person might be in clinic (AM) or floor consults (PM if no PM clinic). Have someone share the .ahm ortho consult note template w/ you, and you can start the consult notes and share w/ the resident covering the floor that day. Being in clinic is challenging b/c of the volume of patients and the efficiency

of the residents. You can ask to see some clinic patients on your own maybe later in the month, but don't forget to start a clinic visit note and have your resident/attending finish the clinic note.

The sub-I and intern will show you how to setup Epic for ortho on your first day (I would recommend getting there at 5am on your first Mon). And all the residents are very approachable and down to earth, so don't be afraid to ask if any questions.

Attire

Never need to bring white coat or to dress up. No need for steth either. You can bring a jacket b/c it gets cold in ortho clinic. Always have a pair of trauma shears in your scrub pockets. You can borrow a pair for the month from the resident workroom on the first day.

Ortho call:

If you're on busy call, then let the resident on call know that you're only staying until midnight so they won't think you're slacking. In general, the chief or senior will give you a little orientation on the first day. After that, don't discuss call w/ them (i.e. which nights you should take). Work it out between amongst the MS3s and w/ sub-I. You can check the resident call schedule via web-paging > on-call search > ortho/hc.

Sub-I:

Always let your sub-I choose from the OR cases first. Just keep in mind that as MS3s we're just here to learn, whereas they're there to shine and do really well! Support them however you can in helping them to shine, and they'll really appreciate it.

Pimping:

Not much. Maybe 1 question per surgery re: what's this nerve I'm clamping in the leg? Or what arteries/veins run in this leg compartment? Again, prepping OR cases the day before will be helpful. But in reality, you'll mostly be asked questions during bone boards.

Door Codes

Ortho clinic: 5-2-1

Supply room: 5-3-1

Resources

- Orthobullets.com:
 - Good for surgical Techniques
 - Good for Post op management
 - Good for classifications
 - Good for images
 - Good for random facts
 - Not good for relevant anatomy
 - Not good for finding references
- Whelessonline.com:
 - Good for finding relevant papers
 - Good for indications
 - Good for some images
- AO Surgery App: great for approaches andn fx classification
- Ortho trauma app: ditto above